Pharmacy Provider Manual for New Hampshire Medicaid

Version 3.1

February 20, 2019

Magellan Medicaid Administration, part of the Magellan Rx Management division of Magellan Health, Inc.

Revision History

Document Version	Date	Name	Comments
1.0	11/03/2001	Implementation Team	Implementation
1.1	07/16/2003	Jeannie Goodyear	NCPDP 5.1 implementation
2.0	09/01/2006	Janet Frazier, Comm. and Documentation Management	Edited and reformatted original document
2.1	11/19/2007	Rob Coppola, Lise Farrand	Reviewed
2.2	01/24/2010	Training and Development	Reviewed, edited, and revised document
2.3	03/02/2010	Training and Development	Edited
2.4	06/09/2010	Comm. and Documentation Management	Updated for name change
2.5	06/22/2010	Training and Development	Edited per client review
2.6	01/31/2013	Comm. and Documentation Management	Rebranded
2.7	04/14/2015	Comm. and Documentation Management	Rebranded
2.8	10/27/2017	Lise Farrand	Reviewed, edited
3.0	12/01/2018	Account Management; Leslie Fisher	Annual Review; revised
3.1	02/20/2019	Account Management; Leslie Fisher	Updated Magellan's address to P.O. Box 9971, Glen Allen, VA 23060

Table of Contents

1.0 Introduction

1.1 New Hampshire Department of Health and Human Services Fee-for-Service Pharmacy Program

This manual provides claims submission guidelines for the Medicaid Fee-for-Service (FFS) pharmacy program administered by the New Hampshire Department of Health and Human Services (NH DHHS).

Important NH DHHS coverage and reimbursement policies are available in this *Pharmacy Provider Manual for New Hampshire Medicaid FFS Program*. The Magellan Medicaid Administration website for NH DHHS contains a link to this document. Subsequent revisions to this document will be available by accessing this link.

Note: For the most current version of this manual, refer to the Magellan Medicaid Administration website at https://newhampshire.magellanmedicaid.com.

1.2 Pharmacy Benefit Manager (PBM) – Magellan Medicaid Administration

NH DHHS contracts with Magellan Medicaid Administration, a Magellan Rx Management division of Magellan Health, Inc., as its pharmacy benefit manager to:

- Adjudicate claims;
- Provide Technical and Clinical Call Center services for providers;
- Review and adjudicate prior authorization requests;
- Perform Prospective Drug Utilization Review (ProDUR) and Retrospective Drug Utilization Review (RetroDUR); and
- Provide clinical consultation.

2.0 Billing Overview

2.1 Enrolling as a DHHS-Approved Pharmacy

The New Hampshire Medicaid pharmacy provider network will consist of DHHS-contracted pharmacies. To enroll as a Medicaid pharmacy provider, contact the Provider Enrollment Unit:

- 603-223-4774 (in state)
- 866-291-1674 (out of state)
- Hours: Monday–Friday, 8:00 a.m.–5:00 p.m. Eastern Time

All billing providers must have an active National Provider Identifier (NPI). Providers must submit the NPI only in the Service Provider ID field (NCPDP Field # 201-B1).

2.2 Claim Formats and DHHS – Specific Values

Pharmacy claims may be submitted online by Point-of-Sale (POS), by

- **POS:** NCPDP Version D.0
- **Paper:** Universal Claim Form (UCF – DAH). Refer to *Appendix A – Universal Claim Form* for instructions.
- **Batch Media:** Must use the National Council for Prescription Drug Programs (NCPDP) Batch 1.2 format. Batch specification can be obtained directly from NCPDP via their website: www.ncpdp.org.
- Supplies that are submitted on Centers for Medicare and Medicaid Services (CMS) (formerly, Health Care Financing Administration [HCFA]) 1500 claim forms should be sent to Conduent at the following address:

  Conduent
  P.O. Box 2003
  Concord, NH 03301-2003

Conduent is the fiscal agent for New Hampshire Medicaid for all other services, except the pharmacy benefit program.

Magellan Medicaid Administration is responsible for pharmacy drug claim reimbursement. Checks and remittance advices (RAs) are distributed on a bi-weekly schedule.

2.3 NCPDP Version D.0

Magellan Medicaid Administration supports NCPDP version D.0. See *Section 9.0 – Appendix B – Payer Specifications* for details.

2.4 Switch Vendors

Switch Vendor Contact List			
Name	**Contact**	**E-Mail Address**	**Telephone Number**
EMDEON	Kristie Ramirez	kristie.ramirez@erxnetwork.com	817-887-0079
	Pam Faletti	pfaletti@emdeon.com	817-887-0284
	24-hour Command Center	commandcenter@emdeon.com	615-231-4620
RELAY HEALTH (NDC)	Network Operations (24/7)	network.ops@relayhealth.com	404-728-2570
	Debra Randels	Debra.randels@relayhealth.com	404-728-2893
	Ginny Jordan	ginny.jordan@relayhealth.com	404-728-2660
QS1	Kevin Crowe	kevin_crowe@qs1.com	864-253-8600 opt 9 ext. 7455

Providers are subject to the transaction fee agreement they have established with their switch vendor. Additionally, Rite Aid supports a direct lease line with Magellan Medicaid Administration for NCPDP version D.0.

2.5 Transaction Type

The following transaction codes are defined according to standards established by the NCPDP. The pharmacy's ability to use these transaction codes will depend on the software used. At a minimum, all providers should have the capability to submit

- Original claims (Transaction Code B1)
- Reversals (Transaction Code B2)
- Re-bill claims (Transaction Code B3)

2.5.1 Full Claims Adjudication (Transaction Code B1)

The full claims adjudication captures and processes the claim and returns to the pharmacy the dollar amount allowed under the New Hampshire Medicaid reimbursement formula. Transaction Code B1 corresponds to 1Ø3-A3 of the D.0 Transaction.

2.5.2 Claims Reversal (Transaction Code B2)

The claims reversal is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void any claim that has received a "Paid" status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system. Transaction Code B2 corresponds to 1Ø3-A3 of the D.0 Transaction. The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- Service Provider ID
- Prescription Number
- Date of Service (date prescription was filled)
- NDC

2.5.3 Claims Re-bill (Transaction Code B3)

The claims re-bill, transaction code B3, is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a "Paid" status. This transaction voids the original claim and resubmits the claim within a single transaction. Transaction code B3 corresponds to 1Ø3-A3 of the D.0 Transaction.

2.6 Required Data Elements

The Magellan Medicaid Administration system contains three categories of data elements used for each transaction. They are:

- Mandatory (M)
- Required (R)
- Qualified Requirement (RW)

The pharmacy provider's software vendor will need the payer specifications before setting up the plan in the pharmacy's computer system. The complete list of New Hampshire Medicaid Payer Specifications, including NCPDP field number references, is found in *Section 9.0 – Appendix B – Payer Specification*. This will allow the provider access to the required fields.

New Hampshire Medicaid claims will not be processed without all the required data elements. Required fields may or may not be used in the adjudication process. Fields not required for this program at this time may be required at a future date. Provider software systems must be able to support any/all data elements on the required segments.

Please note the following descriptions regarding data elements.

Important Note
IMPORTANT NOTE: The following list provides important identification numbers for this program: • ANSI BIN Number: 009513 • Processor Control Number: P002002286 • Group Number: NHMEDICAID • Provider ID: NPI number • Cardholder ID: New Hampshire Medicaid ID Number • Prescriber ID: NPI number • Product Code: National Drug Code (NDC)

2.7 Timely Filing Limits

Most providers submitting via the POS system submit their claims at the time the drug is dispensed. However, there may be mitigating reasons that require a claim to be submitted after the fact. Requests for overrides will be considered for:

- Retroactive recipient eligibility;
- Newborn eligibility;
- Third-party liability (TPL) delay;
- Denied claim status (15 months from the date of service [DOS]); and
- Surveillance and Utilization Review Sub-System (SURS).

For all original claims, reversals, and adjustments the timely filing limit is 366 days from the DOS. Claims that exceed the prescribed timely filing limit will deny.

When appropriate, contact Magellan Medicaid Administration for consideration of an override to timely filing limits.

3.0 Program Particulars

3.1 Dispensing Limits

3.1.1 Days' Supply

There is a per claim days supply maximum of 34 days, except for certain maintenance medications. Exceptions to the 34 days' supply limit include

- ADD/narcolepsy drugs, which have a 60-day supply limit
- Clozaril® (Clozapine), which has a 28-day supply limit
- Oral contraceptives, which have a 90-day supply limit with the exception of Seasonale®, which is only available in quantities of 91. Effective January 1, 2019, a 12 month supply will be allowed if a prescription is written to dispense the full 12 month supply.
- Depo-Provera®, used for contraception, which has a 90-day supply limit. Effective January 1, 2019, a 12-month supply of contraceptives will be allowed if a prescription is written to dispense the full 12 month supply.

The following maintenance medications allow a 90-day supply at POS as noted below:

- Cardiovascular
  - ACE inhibitors and combinations
  - Angiotensin II receptor blockers and combinations
  - Calcium channel blockers and combinations
  - Beta blockers and combinations
  - Statins and combinations
- Gastrointestinal
  - Hepatitis C Agents: Pegylated Interferon Alpha and Ribavirin products
  - Medications for the treatment of gastrointestinal disease
- Arthritis and Analgesic Anti-Inflammatory
  - Cox II inhibitors
  - Medications for the treatment of arthritis
- Endocrinology
  - Bisphosphonates
  - Insulins
  - Biguanides and combinations
  - Meglitinides
  - Alpha-glucosidase inhibitors

  - Second generation Sulfonylureas and combinations
  - Thiazolidinediones and combinations
  - Medications for the treatment of thyroid disease
- Respiratory
  - Short Acting Beta Adrenergics-inhalers and nebulizers
  - Long Acting Beta Adrenergics
  - Inhaled Corticosteroids
  - Nasal Corticosteroids
  - Leukotriene modifiers
- Ophthalmic/Glaucoma
  - Alpha 2 Adrenergic agents
  - Beta Blocker agents
  - Carbonic Anhydrase inhibitors
  - Prostaglandin agonists
- Behavioral Health
  - Atypical Antipsychotics and combinations
  - Novel antidepressants
  - Serotonin Reuptake Inhibitors and combinations
- Neurology
  - Alzheimer's agents
  - Medications for the treatment of seizure disorders
  - Medications for the treatment of Parkinson's disease
- Miscellaneous
  - Allergy symptoms
  - Nutrients such as vitamins, minerals, trace elements, and amino acids
  - Contraception
  - Hormone replacement therapies

Requests for overrides should go to the Magellan Medicaid Administration Clinical Support Center at 1-866-675-7755.

3.1.2 Dispensing Limits by Drug

To access a list of dispensing limitations by drug, go to: https://newhampshire.magellanmedicaid.com. Click the **Provider** tab, select **Documents**, then select **Quantity Limit Program**.

3.2 Refills

Refills must be dispensed in accordance with state and federal regulations. Refills must be dispensed pursuant to the doctor's orders and no more than one year from the original date of issue.

- For CIIs: No refills are allowed.
- For DEA Code = "0": Allow up to 99 refills within 366 days.
- For DEA Code = "III," "IV," or "V": Allow up to 5 refills within 180 days.

3.3 Dispense Fees

The dispense fee is $10.47 per prescription.

Providers submitting long-term care (LTC) claims are limited to one dispense fee per patient per solid oral formulation covered drug per every 25 days of a 30-day supply or 75 percent of the submitted days supply. See *Section 3.10.1 – Long-Term Care (LTC) Claims* for additional information.

3.4 Generic Substitution Policy

New Hampshire Medicaid requires that when available, the therapeutically equivalent generic product will be dispensed. Brand Name Multiple Source Prescription Drugs will deny and require prior authorization.

See *Section 3.9 – Prior Authorization* for additional information about prior authorization.

3.5 Drug Coverage

The following drugs/drug classes are not covered through the pharmacy benefit:

- Drug Efficacy Study Implementation (DESI) drugs
- Fertility agents
- Topical Minoxidil
- Vaniqa®
- Drugs used to treat erectile or sexual dysfunction
- Any drug products used for cosmetic purpose
- Any drugs that are not approved by the U.S. Food and Drug Administration
- Experimental and/or investigational drugs

Drug coverage is based on CMS rebate agreements with the manufacturers. A listing of current CMS rebate manufacturers is included as *Section 10.0 – Appendix C – Active Labelers Report* at the end of this manual.

3.5.1 Multi-Ingredient Compounds

- The Compound Segment information (Segment 10) must be submitted for Multi-Ingredient Compound claims. The fields that are required for compounds are found in the Payer Specification document.
- Home infusion claims will continue to receive the per diem fee, up to a maximum of 10 days per fill. This fee will be automatically paid (no action is required).
- The current co-pays will remain in effect.
- Each ingredient must pass all edits (clinical, rebate, etc.) for coverage. If an ingredient is not covered, the reason for the denial/reject will be passed back to the pharmacy using normal NCPDP denial/reject codes.
- Pharmacists may elect to continue processing the prescription if at least one ingredient is covered, by entering a value of "8" in the Submission Clarification Code (NCPDP field #420-DK)

3.5.2 340B Drugs

- 340B covered entities except for DHHS approved Family planning providers, shall not bill NH Medicaid for drugs purchased through the 340B program.

3.6 Recipient Payment Information

3.6.1 Co-payment

All Medicaid recipients (see exceptions below) are responsible for the following standard co-pays:

- A copay of $1.00 will be required for each preferred prescription drug and each refill of a preferred prescription drug.
- A copay of $2.00 will be required for each non-preferred prescription drug and each refill of a nonpreferred prescription drug, **unless** the prescribing provider determines that a preferred drug will be less effective for the recipient and/or will have adverse effects for the recipient, in which case the copay for the non-preferred drug will be $1.00.
- A copay of $1.00 will be required for a prescription drug that is not identified as either a preferred or nonpreferred prescription drug.

Exceptions to the above (zero co-pay) include:

- Recipients with income at or below 100% of the Federal Poverty Level (FPL).
- Recipients in a nursing facility.
- Recipients participating in the Home and Community Based Care (HCBC) waiver programs.
- Recipients receiving services that relate to pregnancy or any other medical condition that might complicate the pregnancy (New Hampshire does not delineate any service as not pregnancy-related in its state plan so pregnant women are exempt from all copayments).
- Recipients in the Breast and Cervical Cancer Program.
- Recipients receiving hospice care.
- Recipients who are Native American or Alaskan Natives.
- Recipients under the age of 18.

3.6.2 Medicare Part D Dual-Eligible Recipients

Co-pays for Medicare Part D covered drugs will not be covered by New Hampshire Medicaid. Only claims for Medicare Part D excluded drug classes can be processed through the NH Medicaid POS. Standard co-pay information applies for these claims only.

The excluded drug categories that will not be covered by the Medicare Part D plans include:

- Agents used for anorexia, weight loss, or weight gain – Medicaid will continue to require prior authorization for weight loss drugs;
- Rx vitamins and minerals; and
- Over-the-counter (OTC) medications listed on OTC covered item list.

Claims for Medicare Part D-covered drug classes should be processed through the patient's Medicare Part D Prescription Drug Plan (PDP). If a particular drug in a Medicare-covered drug class is not covered, or requires a prior authorization by the Medicare PDP, the prescriber should either obtain a prior authorization from the PDP or choose a drug that is covered by the Medicare Part D plan.

3.7 Coordination of Benefits (COB)

Claims for coordination of benefits (COB) in which New Hampshire Medicaid is not the primary payer will be processed online. In those cases in which the recipient has other insurance coverage, pharmacy providers will be required to bill all other insurance carriers (including Medicare) before billing New Hampshire Medicaid. NCPDP override conditions will be supported.

No primary insurer co-pays or deductibles should be collected from recipients if the claim is for a covered New Hampshire Medicaid recipient. Only New Hampshire Medicaid co-pays (if applicable) should be collected from the recipients.

3.7.1 Other Coverage Codes

3.7.1.1 Other Coverage Code (NCPDP Field # 308-C8) = "3"

This code indicates that other coverage exists. Any claim not covered should only be submitted if the primary insurance carrier returned an NCPDP 70 – "NDC Not Covered" denial. If the primary carrier requires a prior authorization (NCPDP 75), then the primary carrier's prior authorization procedures must be followed prior to submitting the claim to New Hampshire Medicaid for secondary payment. New Hampshire Medicaid will audit transactions to ensure this policy is strictly followed.

3.7.1.2 Other Coverage Code (NCPDP Field # 308-C8) = "4"

This code indicates that other coverage exists. Any payment not collected should only be submitted if the primary insurance carrier did not cover any portion of the claim due to a recipient's deductible or co-pay obligation. New Hampshire Medicaid will audit transactions to ensure this policy is strictly followed.

3.7.1.3 Other Coverage Code (NCPDP Field # 308-C8) = "5," "6," and "8"

These codes will not be allowed for overrides.

Magellan Medicaid Administration supports the New Hampshire Medicaid proprietary code for Other Payer ID (NCPDP Field #340-7C).

3.7.2 Processing Third-Party Liability (TPL) Claims

If there is payment received from multiple other carriers, the State of New Hampshire requires the total amount paid from all valid carriers be populated in the appropriate field. Even if no other insurance is indicated on the eligibility file, Magellan Medicaid Administration will process the claim as TPL if:

- The pharmacist submits TPL data as indicated in the TPL Processing Grid,
- Other insurance is indicated on the recipient's eligibility file. Magellan Medicaid Administration will then process the claim as TPL regardless of what TPL codes the pharmacist submits.

In all cases, Magellan Medicaid Administration will use the New Hampshire Medicaid "Allowed Amount" when calculating payment. Note that in some cases, this may result in a zero payment.

3.7.3 Cost Avoidance

Federal regulations require states to deny (cost avoid) Medicaid claims until after the application of available TPL benefits. Certain conditions may not be allowed for cost avoidance. There is no cost avoidance if:

- Recipient is pregnant (as indicated by the Special Eligibility Code).
- Recipient is with an absent parent who has a court order to pay. TPL segments for these recipients will not be sent to Magellan Medicaid Administration.

Providers who are out-of-network for the primary should contact Magellan Medicaid Administration for override consideration if:

- No in-network pharmacy provider exists within a ten-mile radius
- In-network pharmacy provider exists within a ten-mile radius but the drug is not available from that provider

3.7.4 Medicaid Care Management

Most Medicaid recipients will receive their pharmacy services through a managed care organization (MCO). If you receive a denied claim for a NH Medicaid recipient: AF-Patient Enrolled Under Managed Care with an additional message regarding MCO plan information, you will need to confirm enrollment and submit the claim to the appropriate MCO.

3.7.5 Pharmacy Carve Out for Care Management Recipients

DHHS carved out of the MCO contracts the following: drugs used for the treatment of Hepatitis C and hemophilia, and the drugs Carbaglu and Ravicti. These carved-out drugs are paid by NH Medicaid Fee-for-Service through Magellan, the DHHS pharmacy vendor.

3.8 Coordination of Benefits/Third-Party Liability Processing Grid

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
0 = Not Specified	0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date	This code will not override TPL.
0 = Not Specified	0	No	Null	Null	**Pay**	
0 = Not Specified	>0	No	M/I or null	M/I or null	**Deny** M/I Other Payer Date	
0 = Not Specified	>0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date M/I Other Payer Amount	
1 = No other coverage identified	0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date	
1 = No other coverage identified	0	Yes	Valid Date	Valid TPL Carrier Code	**Pay**	Use when primary does not show coverage.
1 = No other coverage identified	0	No	M/I or null	M/I or null	**Pay**	
1 = No other coverage identified	>0	No	M/I or null	M/I or null	**Deny** Primary M/I Other Payer Date	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
1 = No other coverage identified	>0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date M/I Other Payer Amount	
1 = No other coverage identified	0	Yes	Valid Date	M/I or null	**Deny** Bill Primary M/I Other Payer Date	
1 = No other coverage identified	0	No	Valid Date	M/I or null	**Deny** M/I Other Payer Date	
1 = No other coverage identified	0	No	M/I or null	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
1 = No other coverage identified	0	Yes	M/I or null	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
1 = No other coverage identified	0	Yes	Valid Date	Invalid TPL Carrier Code	**Deny** Bill Primary	
1 = No other coverage identified	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
2 = Other coverage exists, payment collected	> 0	Yes or No	Valid Date	Valid TPL Carrier Code	**Pay** (Will pay when all carriers have been overridden)	Will pay the difference between the New Hampshire Medicaid Allowed Amount and the Other Payer Amount (and optionally the Patient Paid Amount)
2 = Other coverage exists, payment collected	>0	No	Valid Date	M/I or null	**Deny** M/I Other Payer Date	
2 = Other coverage exists, payment collected	>0	Yes	Valid Date	M/I or null	**Deny** Bill PrimaryM/I Other Payer Date	
2 = Other coverage exists, payment collected	>0	Yes or No	M/I or null	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
2 = Other coverage exists, payment collected	0	No	M/I or null	M/I or null	**Deny** M/I Other Payer Date MI Other Payer Amount	
2 = Other coverage exists, payment collected	0	Yes	N/A	N/A	**Deny** Bill Primary M/I Other Payer Date M/I Other Payer Amount	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
2 = Other coverage exists, payment collected	>0	Yes	Valid Date	Invalid TPL Carrier Code	**Deny** Bill Primary	
2 = Other coverage exists, payment collected	>0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
3 = Other coverage exists, this claim not covered	0	Yes or No	Valid Date	Valid TPL Carrier Code	**Pay**	Pay the New Hampshire Medicaid Allowed Amount.
3 = Other coverage exists, this claim not covered	0	No	Valid Date	0	**Deny** M/I Other Payer Date	
3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	M/I	**Deny** Bill Primary M/I Other Payer Date	
3 = Other coverage exists, this claim not covered	0	Yes or No	M/I or null	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
3 = Other coverage exists, this claim not covered	>0	No	M/I or null	M/I or null	**Deny** Bill Primary, M/I Other Payer Date	
3 = Other coverage exists, this claim not covered	>0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date M/I Other Payer Amount	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
3 = Other coverage exists, this claim not covered	>0	Yes or No	Valid	Valid	**Deny** M/I Other Payer Amount	
3 = Other coverage exists, this claim not covered	>0	Yes	Valid	Invalid	**Deny** Bill Primary M/I Other Payer Amount	
3 = Other coverage exists, this claim not covered	>0	No	Valid	Invalid	**Deny** M/I Other Payer Amount	
3 = Other coverage exists, this claim not covered	>0	Yes or No	Invalid	Valid	**Deny** M/I Other Payer Date M/I Other Payer Amount	
3 = Other coverage exists, this claim not covered	0	Yes	Valid Date	Invalid TPL Carrier Code	**Deny** Bill Primary Payer	
3 = Other coverage exists, this claim not covered	0	Yes	Denial > Adjudication Date	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
4 = Other coverage exists, payment not collected	>0	No	M/I or null	M/I or null	**Deny** M/I Other Payer Date M/I Other Payer Amount	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
4 = Other coverage exists, payment not collected	>0	Yes	M/I or null	M/I or null	**Deny** Bill Primary M/I Other Payer Date M/I Other Payer Amount	
4 = Other coverage exists, payment not collected	>0	Yes or No	Valid	Valid	**Deny** M/I Other Payer Amount	
4 = Other coverage exists, payment not collected	>0	Yes	Valid	Invalid	**Deny** Bill Primary M/I Other Payer Amount	
4 = Other coverage exists, payment not collected	>0	No	Valid	Invalid	**Deny** M/I Other Payer Amount	
4 = Other coverage exists, payment not collected	>0	Yes or No	Invalid	Valid	**Deny** M/I Other Payer Date M/I Other Payer Amount	
4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Valid TPL Carrier Code	**Pay**	Use if primary is full deductible or 100% co-pay.
4 = Other coverage exists, payment not collected	0	Yes	Valid Date	M/I or null	**Deny** Bill Primary M/I Other Payer Date	

COB/TPL Processing Grid						
Other Coverage Code (Field # 308-C8)	**Other Payer Amount Paid (Field # 431-DV)**	**Other Coverage indicated on NH Medicaid Recipient Record**	**Other Payer Date (Field # 443-E8)**	**Other Payer ID (Field # 340-7C)**	**Claim Disposition**	**Comments**
4 = Other coverage exists, payment not collected	0	No	Valid Date	M/I or null	**Deny** M/I Other Payer Date	
4 = Other coverage exists, payment not collected	0	Yes or No	M/I or null	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
4 = Other coverage exists, payment not collected	0	Yes	Valid Date	Invalid TPL Carrier Code	**Deny** Bill Primary	
4 = Other coverage exists, payment not collected	0	Yes	Date > Adjudication Date	Valid TPL Carrier Code	**Deny** M/I Other Payer Date	
5 = Managed care plan denial					**Deny** Drug Not Covered OCC 5/6 Not Allowed for Override	Not allowed for override **Additional Message**: NCPDP 70/ with message
6 = Other coverage denied – not a participating provider					**Deny** Drug Not Covered OCC 5/6 Not Allowed for Override	Not allowed for override **Additional Message**: NCPDP 70/ with message
8 = Claim is billing for co-pay					**Deny** Not Allowed for Override	

3.9 Prior Authorization

The prescriber should initiate prior authorization requests. Ideally, this should occur at the point at which the prescription is being written. If the prescribing provider does not initiate the prior authorization process, the claim will deny at POS with a message saying that the prescriber should contact Magellan Medicaid Administration for prior authorization consideration.

Magellan Medicaid Administration will work with the prescriber to determine the outcome of the prior authorization request. Often, a change will be made to the requested drug or dose. The requested drug may be authorized or denied. This decision is made on a case-by-case basis.

If Magellan Medicaid Administration knows who the pharmacy provider is, Magellan Medicaid Administration will contact the provider and advise them of the outcome.

3.9.1 Contacting Magellan Medicaid Administration

Magellan Medicaid Administration's Clinical Support Center staff is available on site from 8:00 a.m.–10:00 p.m. Monday through Friday by calling 1-866-675-7755. After posted hours, calls to the Clinical Support Center roll over to the Technical Support Center. The Technical Support Center will follow up with an on-call pharmacist when necessary.

Magellan Medicaid Administration will respond to all prior authorization requests within 24 hours of the prescriber initiating the request.

3.9.2 Prior Authorization Tips

If the prescriber cannot be contacted within a reasonable period of time, Magellan Medicaid Administration will authorize a 72-hour emergency fill at the request of the pharmacy provider. Pharmacies must request the override to be reimbursed.

Prior authorization records are entered in the claims processing system by Magellan Medicaid Administration for a reasonable amount of time as determined by the nature of the drug, drug class, and any follow-up activity that needs to occur.

It is not necessary to enter a prior authorization number when transmitting the claim. An active prior authorization record in the Magellan Medicaid Administration system is all that is necessary. If there is no active prior authorization record or it has expired, then the pharmacy will receive an NCPDP 75 denial, indicating prior authorization required.

Prior authorization edits will apply to all claims types and claims media.

3.9.3 Drugs that Require Prior Authorization

The Clinical Prior Authorization (PA) Program was implemented to improve quality and manage drug classes that have been identified as requiring additional monitoring. This program is also intended as a means of ensuring that drugs are being prescribed for the right patients and for the appropriate reasons, while still monitoring drug expenditures. Drugs that require prior authorization, their clinical criteria, and the applicable prior authorization forms are located on the Department of Health and Human Services Pharmacy Benefit website under the clinical prior authorization section. (https://www.dhhs.nh.gov/ombp/pharmacy/index.htm)

3.10 Special Recipient Conditions

3.10.1 Long-Term Care (LTC) Claims

LTC claims are identified by the presence of an active LTC segment on the recipient's eligibility file for the DOS as well as by a special eligibility indicator. Some drugs and supplies are not covered for LTC patients through POS; they are covered in the patient's per diem. Also, there is no co-pay to the recipient on LTC claims.

The LTC file may not be up to date due to data lag. In the event that a provider submits a claim anticipating that the claim should process as LTC and it does not, the Provider should enter PATIENT RESIDENCE CODE = "3" (nursing home), and Magellan Medicaid Administration will consider the claim as LTC and process as such if either the designated LTC information is on eligibility file OR if the Provider submits PATIENT RESIDENCE CODE = "3."

3.10.2 Dispensing Fee Limits for LTC Claims

Providers submitting LTC claims are limited to one dispensing fee per patient per covered drug per month. "Per month" will be considered to be 75 percent of a 34-day supply; this definition institutes a limit of 1 dispense fee per every 25 days for the provider. "Per covered drug" will be considered to be "per GSN." (A GSN, or Generic Sequence Number, includes all drugs sharing the same chemical composition, in the same strength, in the same form, and that are administered via the same route.)

Providers may override the single dispense fee limit for mitigating circumstances by entering a value of "5" (exemption from prescription limits) in the Prior Authorization Type Code field. Some mitigating circumstances are:

- Cases where the physician has prescribed a second round of medication within the 25-day period;
- Cases where the physician has increased the dose;
- Cases where the medication did not last for the intended days supply;
- Cases where the drug has been compromised by accident (e.g., contaminated or destroyed);
- Cases where the medication is being dispensed due to the patient's leave of absence (LOA) from the institution; and
- Controlled substances where dispensing is limited due to concern about the patient's ability to take appropriately.

Unused portions of unit dose drugs shall be returned by the nursing facility or other licensed facility to the LTC pharmacy provider when allowed in accordance with 21 CFR 1306 or applicable state law. Providers should void the original claim and re-bill the true used portion.

LTC claims will be subject to the same edits as other pharmacy claims unless specifically noted otherwise. Exception: LTC claims will bypass the Proton Pump Inhibitor Prior Authorization (PPI PA) required edit (see *Section 5.2 – Point of Sale (POS) Reject Codes* for prior authorization edit codes).

4.0 Prospective Drug Utilization Review (ProDUR)

ProDUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Magellan Medicaid Administration assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications, providing information to the dispensing pharmacist that may not have been previously available.

Because the Magellan Medicaid Administration ProDUR system examines claims from all pharmacies participating in the network, drugs that interact or are affected by previously dispensed medications can be detected. Magellan Medicaid Administration recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

The Magellan Medicaid Administration ProDUR system is an integral part of the New Hampshire Medicaid Pharmacy Program's claims adjudication process. ProDUR includes:

- Reviewing claims for therapeutic appropriateness before the medication is dispensed;
- Reviewing the available medical history;
- Focusing on those patients at the highest severity of risk for harmful outcome; and
- Intervening and/or counseling when appropriate.

4.1 Therapeutic Problems

Listed below are all ProDUR conflict types within the Magellan Medicaid Administration system for the New Hampshire Medicaid program:

- Drug-Drug Interaction
- Overuse/Early Refill
- Therapeutic Duplication (except for laxatives)
- Ingredient Duplication (message only/no denials)

ProDUR edits that deny, other than for ProDUR conflict type 2 (Overuse/Early Refill) may be overridden by the pharmacy provider at POS using the interactive NCPDP DUR override codes. For provider level overrides, New Hampshire Medicaid has indicated which codes are allowed (see *Section 5.0 – Edits* for additional information).

ProDUR conflict type 2 (Overuse/Early Refill) can only be overridden by contacting the Magellan Medicaid Administration Technical Support Center at 1-866-664-4511 and requesting an override.

ProDUR denial edits will apply to all media types.

4.2 Days' Supply

Days' supply information is critical to the edit functions of the ProDUR system. Submitting incorrect days supply information in the days supply field can cause false ProDUR messages or claim denial for that particular claim or for drug claims that are submitted in the future.

4.3 Technical Support Center

The Magellan Medicaid Administration Technical Support Center is available 24 hours a day, 7 days a week. The telephone number is 1-866-664-4511. Alert message information is available from the Technical Support Center after the ProDUR message appears. If you need assistance with any Magellan Medicaid Administration ProDUR alert or denial messages, it is important to contact the Technical Support Center at the time of dispensing. The Technical Support Center can provide claims information on all error messages that are sent by the ProDUR system. This information includes:

- NDCs and drug names of the affected drugs;
- Dates of service;
- Whether the calling pharmacy is the dispensing pharmacy of the conflicting drug; and
- Days' supply.

The Technical Support Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. Magellan Medicaid Administration has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, Magellan Medicaid Administration staff pharmacists are available for consultation by calling the Clinical Support Center at 866-675-7755.

4.4 ProDUR Alert/Error Messages

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

Format	Field Definitions
Reason for Service/Conflict Code	**Up to 3 characters** Code transmitted to pharmacy when a conflict is detected: • Early Refill (ER) • High Dose (HD) • Therapeutic Duplication (TD) • Drug-Drug Interaction (DD)
Severity Index Code	**1 character** Code indicates how critical a given conflict is
Other Pharmacy Indicators	**1 character** Indicates if the dispensing provider also dispensed the first drug in question: • 0 = Not specified • 1 = Your pharmacy • 2 = Other pharmacy in same chain • 3 = Other pharmacy
Previous Date of Fill	**8 characters** Indicates previous fill date of conflicting drug in YYYYMMDD format
Quantity of Previous Fill	**5 characters** Indicates quantity of conflicting drug previously dispensed
Database Indicator	**1 character** Indicates source of ProDUR message: • 1 = First DataBank • 4 = Processor Developed
Other Prescriber	**1 character** Indicates the prescriber of conflicting prescription: • 0 = Not specified • 1 = Same Prescriber • 2 = Other Prescriber

5.0 Edits

5.1 Online Claims Processing Messages

Following an online claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "Paid" message will be returned with New Hampshire Medicaid's allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message.

As is shown below, an NCPDP error code is returned with an NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the Solutions box (below) if you are experiencing difficulties. For further assistance, contact the Magellan Medicaid Administration Technical Call Center at 866-664-4511.

5.2 Point-of-Sale (POS) Reject Codes

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
00	("M/I" Means Missing/Invalid)		
01	M/I Bin	101	Use 009513
02	M/I Version Number	102	Use 51
03	M/I Transaction Code	103	Transactions allowed: • B1 • B2 • B3
04	M/I Processor Control Number	104	Use P00002002286
05	M/I Pharmacy Number	201	Use National Provider ID number only; do not send NH Medicaid ID. Must have contract with NH Medicaid for DOS Check with software vendor to ensure appropriate number has been set up in your system.
06	M/I Group Number	301	Use NH MEDICAID only

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
07	M/I Cardholder ID Number	302	Use NH Medicaid Recipient ID number only; do not use any other patient ID. Do not enter any dashes. Providers should always examine a recipient's Medicaid ID card before services are rendered. It is the provider's responsibility to establish the identity of the recipient and to verify the effective date of coverage for the card presented.
08	M/I Person Code	303	
09	M/I Birth Date	304	Format = CCYYMMDD
1C	M/I Smoker/Non-Smoker Code	334	Field not used at this time for this program
1E	M/I Prescriber Location Code	467	Field not used at this time for this program
10	M/I Patient Gender Code	305	Values: • 0/not specified • 1/male • 2/female
11	M/I Patient Relationship Code	306	Allowed value = 1/ cardholder
12	M/I Place of Service	307	Allowed value: • 3/nursing home • 4/long-term/extended care • 11/hospice
13	M/I Other Coverage Code	308	(See *Section 3.7 – Coordination of Benefits (COB)* for additional coordination of benefits information.)
14	M/I Eligibility Clarification Code	309	
15	M/I Date of Service	401	
16	M/I Prescription/Service Reference Number	402	Validate all appropriate codes on refill are same as original fill
17	M/I New-refill code	403	
19	M/I Days Supply	405	
2C	M/I Pregnancy Indicator	335	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
2E	M/I Primary Care Provider ID Qualifier	468	
20	M/I Compound Code	406	
21	M/I Product/Service ID	407	
22	M/I Dispense as Written (DAW)/Product Selection Code	408	
23	M/I Ingredient Cost Submitted	409	
25	M/I Prescriber ID	411	
26	M/I Unit of Measure	600	
28	M/I Date Prescription Written	414	
29	M/I Number Refills Authorized	415	
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	503	
3R	Prior Authorization Not Required	407	
3S	M/I Prior Authorization Supporting Documentation	498-PP	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
3T	Active Prior Authorization Exists Resubmit at Expiration of Prior Authorization		
3W	Prior Authorization in Process		
3X	Authorization Number Not Found	503	
3Y	Prior Authorization Denied		
32	M/I Level of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	420	
35	M/I Primary Care Provider ID	421	
38	M/I Basis of Cost	423	
39	M/I Diagnosis Code	424	
4C	M/I Coordination of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	570	
40	Pharmacy Not Contracted with Plan on Date of Service		
41	Submit Bill to Other Processor or Primary Payer		Refer to additional messaging in Additional Message field for: • Other payer ID • Name • Policy number (if available)
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
50	Non-Matched Pharmacy Number	201	
51	Non-Matched Group ID	301	
52	Non-Matched Cardholder ID	302	Validate patient's first and last name
53	Non-Matched Person Code	303	
54	Non-Matched Product/Service ID Number	407	
55	Non-Matched Product Package Size	407	
56	Non-Matched Prescriber ID	411	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	Enter 99/other
6E	M/I Other Payer Reject Code	472	
60	Product/Service Not Covered for Patient Age	302, 304, 401, 407	
61	Product/Service Not Covered for Patient Gender	302, 305, 407	
62	Patient/Card Holder ID Name Mismatch	310, 311, 312, 313, 320	Validate patient's first and last name
63	Institutionalized Patient Product/Service ID Not Covered		
64	Claim Submitted Does Not Match Prior Authorization	201, 401, 404, 407, 416	
65	Patient is Not Covered	303, 306	
66	Patient Age Exceeds Maximum Age	303, 304, 306	
67	Filled Before Coverage Effective	401	
68	Filled After Coverage Expired	401	
69	Filled After Coverage Terminated	401	
7C	M/I Other Payer ID	340	
7E	M/I DUR/PPS Code Counter	473	
70	Product/Service Not Covered	407	
71	Prescriber ID Is Not Covered	411	
72	Primary Prescriber is Not Covered	421	
73	Refills are Not Covered	402, 403	
74	Other Carrier Payment Meets or Exceeds Payable	409, 410, 442	
75	Prior Authorization Required	462	
76	Plan Limitations Exceeded	405, 442	
77	Discontinued Product/Service ID Number	407	
78	Cost Exceeds Maximum	407, 409, 410, 442	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
79	Refill too Soon	401, 403, 405	
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level of Effort	474	
80	Drug-Diagnosis Mismatch	407, 424	
81	Claim too Old	401	Claim exceeds filing limit, validate DOS
82	Claim is Post-Dated	401	DOS is greater than submittal date
83	Duplicate Paid/Captured Claim	201, 401, 402, 403, 407	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Reversals must match on • Provider Number • Rx Number • DOS • NDC
88	DUR Reject Error		
89	Rejected Claim Fees Paid		Response not in appropriate format to be displayed
90	Host Hung Up		Processing host did not accept transaction/did not respond within time out period
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payor Unavailable		
98	Connection to Payor is Down		
99	Host Processing Error		Do not retransmit claim(s).
AA	Patient Spend Down Not Met		
AB	Date Written is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
AD	Billing Provider Not Eligible to Bill this Claim Type		
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation for Product/Service		
AH	Unit Dose Packaging Only Payable for Nursing Home Recipients		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	110	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	109	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	202	
CA	M/I Patient First Name	310	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	320	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	
CW	M/I Alternate ID	330	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis of Cost Determination	423	
DQ	M/I Usual and Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Special Packaging Indicator	429	
DU	M/I Gross Amount Due	430	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	
DY	M/I Date of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	450	
EG	M/I Compound Dispensing Unit Form Indicator	451	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
EH	M/I Compound Route of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	460	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization ID Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason for Service Code	439	Enter appropriate DUR problem type (e.g., “ER” = Early Refill) for override consideration
E5	M/I Professional Service Code	440	Enter appropriate DUR intervention type (e.g., “M0” = prescriber consulted) for override consideration
E6	M/I Result of Service Code	441	Enter appropriate DUR outcome type (e.g., “1A” = filled as is, false positive) for override consideration

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
E7	M/I Quantity Dispensed	442	Enter appropriate metric decimal quantity
E8	M/I Other Payer Date	443	Used for coordination of benefits. Enter valid date Other payer paid or denied the primary claim. Date must be =/< DOS of claim to Medicaid
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	
HF	M/I Quantity Intended to Be Dispensed	344	
HG	M/I Days Supply Intended to Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
H9	M/I Other Amount Claimed Submitted	480	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered in this Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	
NN	Transaction Rejected at Switch or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count for this Transaction Code	103, 109	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Employer ID Not Covered	333	
PX	Other Payer ID Not Covered	340	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 600	
PZ	Non-Matched Unit of Measure to Product/Service ID	407, 600	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number of Repetitions	447	
P4	Coordination of Benefits/Other Payments Count Does Not Match Number of Repetitions	337	
P5	Coupon Expired	486	
P6	Date of Service Prior to Date of Birth	304, 401	
P7	Diagnosis Code Count Does Not Match Number of Repetitions	491	
P8	DUR/PPS Code Counter Out of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out of Order		
RB	Multiple Partials Not Allowed		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
RC	Different Drug Entity Between Partial and Completion		
RD	Mismatched Cardholder/Group ID-Partial to Completion	301, 302	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order of "Dispensing Status" Code on Partial Fill Transaction		
RG	M/I Associated Prescription/Service Reference Number on Completion Transaction	456	
RH	M/I Associated Prescription/Service Date on Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not on File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted with Same "Date of Service" as Partial Transaction	401	
RN	Plan Limits Exceeded on Intended Partial Fill Values	344, 345	
RP	Out of Sequence "P" Reversal on Partial Fill Transaction		
RS	M/I Associated Prescription/Service Date on Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number on Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements in a Segment		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
R1	Other Amount Claimed Submitted Count Does Not Match Number of Repetitions	478, 480	
R2	Other Payer Reject Count Does Not Match Number of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid for Product/Service ID	407, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06	407, 436	
R6	Product/Service Not Appropriate for this Location	307, 407, 436	
R7	Repeating Segment Not Allowed in Same Transaction		
R8	Syntax Error		
R9	Value in Gross Amount Due Does Not Follow Pricing Formulae	430	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis of Cost Determination	490	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.3 Host System Problems

Occasionally providers may receive a message that indicates their network is having technical problems communicating with Magellan Medicaid Administration.

NCPDP	Message	Meaning
90	Host Hung Up	Host disconnected before session completed.

NCPDP	Message	Meaning
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
93	Planned Unavailable	Transmission occurred during scheduled downtime. The system is normally available 24/7/365 except for regularly scheduled downtime from Saturday 11:00 p.m. until Sunday 6:00 a.m.
99	Host Processing Error	Do not retransmit claims.

5.4 DUR Fields

Providers may override certain denials for ProDUR edits using the appropriate codes. They are:

- DUR Reason of Service (Conflict Code);
- Professional Result (Intervention Code); and
- Result of Service (Outcome Code).

The Early Refill edit requires the pharmacy to contact the Magellan Medicaid Administration Technical Support Center at 866-664-4511 for an override.

These are the ProDUR edits that will deny for New Hampshire Medicaid:

- Early Refill
- Drug/Drug Interactions
- Therapeutic Duplication

5.4.1 DUR Reason for Service/Conflict Code

The DUR Reason for Service/Conflict Code is used to define the type of utilization conflict that was detected (NCPDP Field # 439).

Valid DUR Reasons for Service/Conflict Codes for the New Hampshire Medicaid Program are:

- DD = Drug-Drug Interaction;
- ER = Overuse (Early Refill); and
- TD = Therapeutic Duplication.

5.4.2 DUR Professional Service/Intervention Code

The DUR Professional Service/Intervention Code is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field # 440).

Valid DUR Professional Service/Intervention Codes for the New Hampshire Medicaid Program are:

- M0 = Prescriber consulted;
- PE = Patient Education/instruction;
- PH = Patient medication history;
- P0 = Patient consulted;
- PM = Patient monitoring; and
- SW = Literature search/review.

5.4.3 DUR Result of Service

The DUR Result of Service/Outcome code is used to define the action taken by the pharmacist in response to a ProDUR Reason of Service/Outcome or the result of a pharmacist's professional service (NCPDP Field # 441).

Valid DUR Result of Services/Outcome codes for the New Hampshire Medicaid Program are:

- 1A = Filled as is, false positive;
- 1B = Filled prescription as is;
- 1D = Filled with different directions;
- 1G = Filled with prescriber approval; and
- 3C = Discontinued drug.

5.4.4 Submission Clarification Code

The Submission Clarification Code is used to further clarify the submission of a claim and is specifically used in this program to provide additional information regarding provider overrides for Early Refill (NCPDP Field # 420).

Valid Submission Clarification codes for the New Hampshire Medicaid Program are

- 03 = Vacation supply;
- 04 = Lost prescription; and
- 05 = Therapy Change

5.4.5 NCPDP Messages and Codes

NCPDP	Message
88	DUR reject error
E4	M/I DUR conflict/reason for service code
E5	M/I DUR intervention/professional service code
E6	M/I DUR outcome/result of service code
34	M/I submission clarification code

Note: Where applicable, these codes must be used to provide additional information to support an override for Early Refill. The "05" value is typically used when there is an increase in dosage from the prescriber.

6.0 Provider Reimbursement

6.1 Provider Payment Algorithms

Payment will always be based on a "lesser of" calculation. The standard payment rate is the lesser of:

- The Actual Acquisition Cost (AAC) using the National Average Drug Acquisition Cost (NADAC) files when available, plus the dispensing fee;
- The Wholesale Acquisition Cost (WAC), when a NADAC is not available, plus the dispensing fee;
- The usual and customary charge to the general public;
- The NH Maximum Acquisition Cost (MAC) plus the dispensing fee; or
- The Federal Upper Limit (FUL) plus the dispensing fee.

6.2 Provider Reimbursement Schedule

There is a biweekly payment and remittance advice schedule.

7.0 Resources

7.1 Help Desk Telephone Numbers

Help Desk Phone Numbers			
Responsibility	**Help Desk**	**Phone Numbers**	**Availability**
New Hampshire	Medicaid Client Services	800-852-3345 x4344 (in-state) 603-271-4344 (out-of-state)	Monday–Friday 8:30 a.m.–4:30 p.m.
Magellan Medicaid Administration	Member Services	866-664-4506	24/7/365
New Hampshire	Provider Enrollment	866-291-1674 (in state) 603-223-4774 (out-of-state)	Monday–Friday 8:30 a.m.–4:30 p.m.
Magellan Medicaid Administration	Technical Call Center	866-664-4511	24 hours a day, 365 days a year
Magellan Medicaid Administration	Prior Authorization	866-675-7755	Monday–Friday 8:30 a.m.–4:30 p.m. After hours: Calls roll over to Technical Call Center, on-call clinical staff is contacted via cell phone

Important Note: The NPI Number will be required for the Service Provider ID (Field # 201-B1) and Prescriber (Field # 411-DB) for all claim submissions.

- The National Provider Identifier is required on all claims submissions.
- Pharmacies and prescribers may apply through a Web-based application process.
- The Web address is https://nppes.cms.hhs.gov

7.2 Important Addresses

Address	Format
Provider Paper Claims Billing Address: Magellan Medicaid Administration New Hampshire Medicaid Paper Claims Processing Unit P.O. Box 9971 Glen Allen, VA 23060	**Format:** Universal Claim Form (UCF)

Address	Format
Provider EMC Billing Address (Tapes/Carts/Diskettes): Magellan Medicaid Administration Media Control/New Hampshire Medicaid EMC Processing Unit 11013 W. Broad Street, Suite 500 Glen Allen, VA 23060	**Format:** NCPDP Batch 1.2
FTP: Magellan Medicaid Administration	**Format:** National Council for Prescription Drug for Programs (NCPDP) Batch 1.2
Conduent P.O. Box 2003 Concord, NH 03302-2003	**Format:** CMS 1500 forms (any CMS 1500 forms sent to Magellan Medicaid Administration will be returned to the provider to be submitted to Conduent.

7.3 Service Support

7.3.1 Online Certification

Providers should contact Magellan Medicaid Administration or their software vendor to determine if the vendor is certified with Magellan Medicaid Administration. The software vendor/certification number (NCPDP Field # 110-AK) is required for claim submission in the NCPDP version D.0. For assistance with software vendor certification, please call 804-548-0130.

7.3.2 Online System Not Available

If the Magellan Medicaid Administration online POS system is not available, providers should submit claims when the online capability resumes. The provider's software should have the capability to submit backdated claims. In the case of system downtime, the medication can be dispensed only if recipient eligibility is verified through the automated voice response (AVR) system.

Once the eligibility is verified, the provider should bill New Hampshire Medicaid when the POS system is back on line. New Hampshire Medicaid will only pay claims for eligible patients.

7.3.3 Technical Problem Resolution

To resolve technical problems, providers should follow the steps outlined below:

- Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.
- If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with Magellan Medicaid Administration to resolve the problem.
- If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with Magellan Medicaid Administration to resolve the problem.
- If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the Magellan Medicaid Administration Technical Support Center at:

  Technical Support Center
  Richmond, VA
  1-866-664-4511

8.0 Appendix A – Universal Claim Form

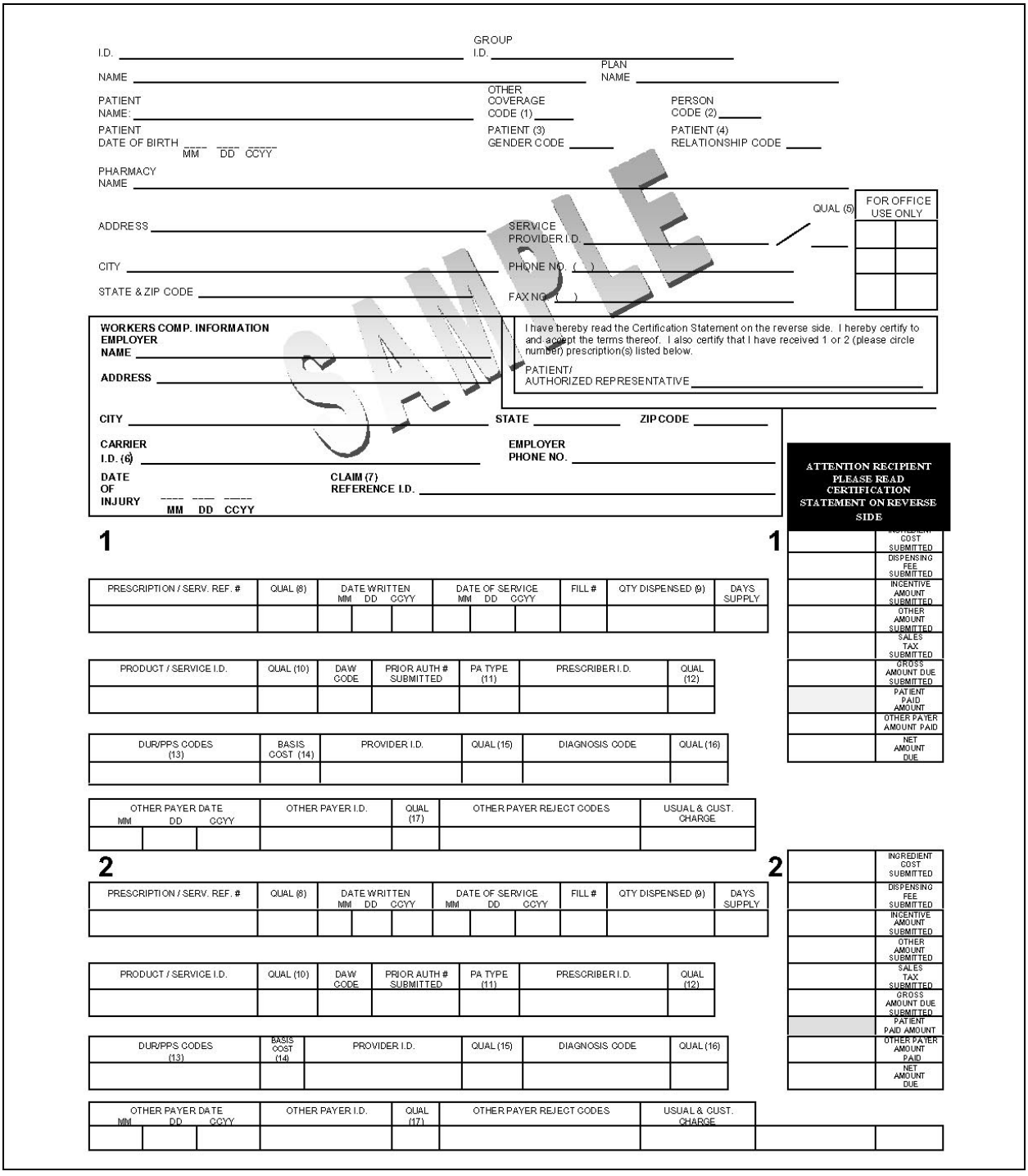

Figure 8.1 – Universal Claim Form Sample

8.1 How to Complete 5.1 UCF Form

1. Fill in all applicable areas on the front of the form.
2. Verify that the patient information is correct and that the patient named is eligible for benefits.
3. Verify that the appropriate section on the front side has been completed if this claim is for a worker's compensation injury.
4. The patient signs the certification on the front side for any prescription(s) received.
5. Enter "Compound RX" in the Product Service ID area and list each ingredient name, NDC, quantity, and cost on the reverse of the form. Please use a separate claim form for each compound prescription.
6. Workers' Compensation information is conditional. It should be completed only for a Workers' Compensation Claim.
7. Report diagnosis code and qualifier related to prescription (limit one per prescription).
8. Limit one set of DUR/PPS codes per claim.
9. Each area is numbered. Fill each area using the Other Coverage codes.

8.2 Other Coverage Codes

Other Coverage Codes	
Values	**Definitions**
0	Not specified
1	No other coverage identified
2	Other coverage exists; payment collected
3	Other coverage exists; this claim not covered
4	Other coverage exists; payment not collected
5	Managed care plan denial
6	Other coverage denied; not a participating provider
8	Claim is billing for ~~a co-pay~~ Patient Responsibility

Person Codes (Assigned to a specific person within a family)	
Patient Gender Codes	
Values	**Definitions**
0	Unknown
Patient Gender Codes	
Values	**Definitions**
1	Male
2	Female
Patient Relationship Codes	
Values	**Definitions**
1	Subscriber
2	Spouse
3	Dependent
4	Other

8.3 Service Provider ID Qualifier

Service Provider ID Qualifier	
Values	**Definitions**
Blank	Not specified
01	National Provider Identifier (NPI)
02	Blue Cross
03	Blue Shield
04	Medicare
05	Medicaid
06	Unique Physician Identification Number (UPIN)
07	NCPDP number
08	State license
09	Champus
10	Health Industry Number (HIN)
11	Federal Tax ID
12	Drug Enforcement Administration (DEA)
13	State issued
14	Plan specific
99	Other

- Carrier ID: Carrier code assigned in Workers' Compensation Program
- Claim Reference ID: Identifies the claim number assigned by Workers' Compensation Program

8.4 Prescription Service Reference Number Qualifier

Prescription Service Reference Number Qualifier	
Values	**Definitions**
Blank	Not specified
1	Rx billing
2	Service billing

8.5 Product Service ID Qualifier

Product Service ID Qualifier (Code qualifying the value in Product/Service ID [407-07])	
Values	**Definitions**
Blank	Not specified
00	Not specified
01	Universal Product Code (UPC)
02	Health Related Item (HRI)
03	National Drug Code (NDC)
04	Universal Product Number (UPN)
05	Department of Defense (DOD)
06	Drug Use Review Professional Pharmaceutical Services (DUR/PPS)
07	Common Procedure Terminology (CPT4)
08	Common Procedure
09	HCFA Common Procedural Coding System (HCPCS)
10	Pharmacy Practice Activity Classification (PPAC)
11	National Pharmaceutical Product Interface Code (NAPPI)
12	International Article Numbering System (EAN)
13	Drug Identification Number (DIN)
99	Other

8.6 Prior Authorization Type Codes

Prior Authorization Type Code	
Values	**Definitions**
0	Not specified
1	Prior authorization
2	Medical certification
3	EPSDT (Early Periodic Screening Diagnosis Treatment)
4	Exemption from co-pay
5	Exemption from Rx limits
6	Family planning indicator
7	Aid to Families with Dependent Children (AFDC)
8	Payer defined exemption

8.7 DUR/Professional Service Codes

DUR/Professional Service Codes (For values refer to current NCPDP data dictionary)	
Values	**Definitions**
A	Reason for service
B	Professional service code
C	Result of service

8.8 Basis of Cost Determination

Basis of Cost Determination	
Values	**Definitions**
Blank	Not specified
00	Not specified
01	AWP (average wholesale price)
02	Local wholesale
03	Direct
04	EAC (estimated acquisition cost)
05	Acquisition
06	MAC (maximum allowable cost)
07	Usual and customary
09	Other

8.9 Provider Service ID Qualifier

Provider Service ID Qualifier	
Values	**Definitions**
01	National Provider Identifier (NPI)

8.10 Diagnosis Code Qualifier

Diagnosis Code Qualifier	
Values	**Definitions**
Blank	Not specified
00	Not specified
01	International Classification of Diseases (ICD9)
02	International Classification of Diseases (ICD10)
03	National Criteria Care Institute (NCCI)
04	Systemized Nomenclature of Medicine (SNOMED)
05	Common Dental Term (CDT)
07	American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM-IV)

8.11 Other Payer ID Qualifier

Other Payer ID Qualifier	
Values	**Definitions**
Blank	Not specified
01	National Payer ID
02	Health Industry Number (HIN)
03	Bank Information Number (BIN)
04	National Association of Insurance Commissioners (NAIC)
09	Coupon
99	Other

Note: Compound prescriptions have a limit of one compound prescription per claim form.

9.0 Appendix B – Payer Specifications

The New Hampshire D.0 Payer Specification document can be found at this location: https://nhcontent.magellanmedicaid.com/Downloads/provider/NHRx_Payer_Specification_20130401.pdf.

10.0 Appendix C – Active Labelers Report

For the State of New Hampshire, Department of Health and Human Services, Active Labelers Report, go to https://newhampshire.magellanmedicaid.com.

Under the Pharmacy Provider tab, Documents, the document is called CMS Rebate Participating Manufacturers.

https://nhcontent.magellanmedicaid.com/Downloads/provider/NHRx_CMS_Rebate_Participating_Manufacturers.pdf

11.0 Appendix D – Other Carrier Codes

A current list of Other carrier codes are located at:
https://newhampshire.magellanmedicaid.com.

12.0 Appendix E – Acronyms

Acronym	Definition
AAC	Actual Acquisition Cost
AFDC	Aid to Families with Dependent Children
AVR	Automated Voice Response System
BIN	Bank Information Number
CDT	Common Dental Term
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT4	Common Procedure Terminology
DAW	Dispense as Written
DEA	Drug Enforcement Administration
DESI	Drug Efficacy Study Implementation
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DOD	Department of Defense
DOS	Date of Service
DUR/PPS	Drug Utilization Review/Professional Pharmaceutical Services
EAN	International Article Numbering System
EPSDT	Early Periodic Screening Diagnosis Treatment
FTP	File Transfer Protocol
FUL	Federal Upper Limit
GSN	Generic Sequence Number
HCBC	Home and Community Based Care
HCFA	Health Care Financing Administration
HCPSCS	HCFA Common Procedural Coding System
HIN	Health Industry Number
HRI	Health Related Item
ICD9	International Classification of Diseases 9
ICD10	International Classification of Diseases 10
LOA	Leave of Absence
LTC	Long Term Care
MAC	Maximum Allowable Cost

Acronym	Definition
MCO	Managed Care Organization
NABP	National Association of Boards of Pharmacy
NADAC	National Average Drug Acquisition Cost
NAIC	National Association of Insurance Commissioners
NAPPI	National Pharmaceutical Product Interface Code
NCPDP	National Council for Prescription Drug Programs
NDC	National Data Corporation
NDC	National Drug Code
NDCC	National Criteria Care Institute
NPI	National Provider Identifier
NSAID	Non-Steroidal Anti-Inflammatory Drugs
OTC	Over the Counter
PA	Prior Authorization
PDP	Prescription Drug Plan
POS	Point of Sale
PPAC	Pharmacy Practice Activity Classification
PPI	Proton Pump Inhibitor
PPI PA	Proton Pump Inhibitor Prior Authorization
ProDUR	Prospective Drug Utilization Review
RA	Remittance Advice
RetroDUR	Retrospective Drug Utilization Review
SNDMED	Systemized Nomenclature of Human and Veterinary Medicine
SSN	Social Security Number
SURS	Surveillance and Utilization Review Sub-System
TPL	Third Party Liability
UCF	Universal Claim Form
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
UPN	Universal Product Number
WAC	Wholesale Acquisition Cost